Verification of Graduation from
Medical School

Please complete this form, attach a picture of yourself and mail to the school of medicine from which you received your M.D. degree. This completed form *must* be received by the South Dakota Board of Medical and Osteopathic Examiners before a South Dakota license is issued.

TO: Dean, School of Medicine

_____
_____
_____

The South Dakota State Board of Medical and Osteopathic Examiners requires that all applicants for licensure must provide verification of graduation from medical school and **identification of a picture** before a license can be issued. Please complete this form and mail it to the following address:

South Dakota Board of Medical
and Osteopathic Examiners
125 South Main Avenue
Sioux Falls, South Dakota 57104

Applicant's Name _____

Address _____

_____

Picture

Year of Graduation _____

This section is to be completed by the Medical School and returned **directly** to the South Dakota State Board of Medical and Osteopathic Examiners.

Name of Medical School _____

Address of Medical School _____

_____

Name of Graduate _____

Year of Graduation _____

**I hereby certify the attached picture is a likeness of _____

and he/she graduated from _____

on _____.

Signed _____

Title _____

(SEAL)

Date _____

****If the school of graduation cannot identify the picture, please have them indicate the reason they cannot do so directly on this form and return this form to our office.**